Bruyère

Hospice Care Ottawa
When comfort matters most

CENTRALIZED REFERRAL AND TRIAGE TO
HOSPICE CARE OTTAWA AND THE BRUYERE PALLIATIVE CARE UNIT

Referral Principles

- Completion of this referral is a request for an immediate admission to Hospice Care Ottawa or the Bruyere Palliative Care Unit.
- Patients referred to Hospice Palliative Care are centrally triaged based on established criteria into the most appropriate setting.

Admission Criteria

- Submit completed referrals to (fax): 613-562-4226, or via encrypted and password-protected email to bruyereclinicaladmissions@bruyere.org
- For questions about SMART, contact **smart@bruyere.org**

* *Indicates a mandatory field*

I have informed the patient and/ or the patient's substitute decision-maker about the purpose for the collection of the information in this application which will be used to assist in determining admission to Hospice Care Ottawa or the Bruyère Palliative Care Unit based on the needs of the patient, and their consent can be withdrawn at any time by writing to the Privacy Officer of Bruyère Continuing Care (43 Bruyère Street, Ottawa, ON K1N 5C8).

☐ ***Yes, I have completed this task**

* **Priority**

Does this patient require an immediate admission (<24 hours) to Hospice/Palliative Care? ☐ No ☐ Yes

If YES, Reason:

☐ Care needs cannot be managed in community

☐ Home situation unsafe

☐ Patient does not wish to die at home

☐ Other

* Referral Completed By: _____ * Date Completed: _____

* Telephone: _____ Pager/Cell: _____

PATIENT DEMOGRAPHICS

* Surname _____

* Given Name _____

* Sex _____

* Date of Birth (dd/mm/yyy) _____

* Address: _____

* City: _____

* Prov: _____ * Postal Code _____

* Main Phone: _____

* Health Card # _____ *VC _____ * Expiry Date _____

REFERRAL INFORMATION

* Date of Referral _____

* Patient's Current Location _____ Unit _____

* Contact Number _____

Home and Community Care Support Services Involved ☐ No ☐ Yes

* Referring Physician (last name, first name) _____ * Tel.#: _____

Family Physician (last name, first name) _____ Tel. #: _____

PATIENT'S CONTACT INFORMATION

* Primary Contact _____

* Relationship: _____ * Tel. #: _____

Substitute Decision Maker (personal care) _____

Relationship: _____ Tel. #: _____

Power of Attorney for Property _____

Relationship: _____ Tel. #: _____

REASON FOR REFERRAL

* Select All That Apply:

- ☐ End of Life Care (days to weeks)
- ☐ Symptom management and EOL care
- ☐ Pain and Symptom management with potential discharge
- ☐ Other _____

MEDICAL INFORMATION

Note: See last page should additional space be required

* Main Diagnosis

Date of Diagnosis _____

Summary of treatments (i.e. chemo, radiation, dialysis):

Noteworthy complications of main diagnosis (i.e. spinal cord compression, delirium):

Noteworthy Past Medical History:

* Weight _____ ☐ lbs ☐ kg

Allergies

* Infections requiring precautions:	☐ None	☐ MRSA	☐ ESBL	☐ CPE
	☐ C-DIFF	☐ Active TB	☐ Shingles	
	☐ Other			

Details of precautions in place

* Does patient require the use of a negative pressure room?	☐ No	☐ Yes
* Has patient used cytotoxic medications in the last 72 hours?	☐ No	☐ Yes
If Yes, provide name of medication and timeframe of usage:		

PSYCHOSOCIAL SITUATION

Select all that apply:

- ☐ Patient and/or family coping difficulties
- ☐ Patient lives alone
- ☐ Caregiver stress, illness
- ☐ Family tension
- ☐ Substance abuse
- ☐ Psychiatric issues
- ☐ Behavioural issues
- ☐ Social isolation
- ☐ History of report violence (patient or family)

Please provide details:

GOALS OF CARE AND ADVANCE CARE PLANNING

Date and content of most recent goals of care discussion (i.e. preferred place of death, personal preferences, values, concerns/fears, religious/spiritual requirements/supports):

*DNR ☐ No ☐ Yes ☐ **If YES**, DNR discussed and confirmed with patient/SDM (please forward DNR documentation at time of transfer)

PATIENT SYMPTOM AND NEEDS PROFILE: PALLIATIVE PERFORMANCE SCALE (PPS)

* *Select one*

*√	%	Ambulation	Activity Level & Evidence of Disease	Self-care	Intake	Level of Consciousness
☐	100	Full	Normal *No disease*	Full	Normal	Full
☐	90	Full	Normal *Some disease*	Full	Normal	Full
☐	80	Full	Normal with effort *Some disease*	Full	Normal or reduced	Full
☐	70	Reduced	Can't do normal job or work *Some disease*	Full	As above	Full
☐	60	Reduced	Can't do hobbies or housework *Significant disease*	Occasional assistance needed	As above	Full or confusion
☐	50	Mainly sit/lie	Can't do any work *Extensive disease*	Considerable assistance needed	As above	Full or confusion
☐	40	Mainly in bed	As above	Mainly assistance	As above	Full or drowsy or confusion
☐	30	Bed bound	As above	Total Care	Reduced	As above
☐	20	Bed bound	As above	As above	Minimal	As above
☐	10	Bed bound	As above	As above	Mouth care only	Drowsy or Coma
☐	0	Death				

Has there been a recent change in PPS? ☐ No ☐ Yes

If Yes, please provide details about the recent change:

PAIN AND SYMPTOM MANAGEMENT

* Is the patient currently delirious? ☐ No ☐ Yes

If **YES**, please provide additional details:

* Does the patient have a history of delirium? ☐ No ☐ Yes

If YES, please provide additional details:

* Does the patient wander/exit seek? ☐ No ☐ Yes

* Does the patient have a diagnosis of dementia? ☐ No ☐ Yes

* Please check symptoms most currently active at this time and provide additional details (i.e. severity of symptom, length of time present, level of intensity, remedial efforts to date, etc)

Confusion	☐	Details:
Agitation	☐	Details:
Pain (specify location)	☐	Details:
Fatigue/Drowsy	☐	Details:
Shortness of Breath	☐	Details:
Nausea	☐	Details:
Poor/decreased Appetite	☐	Details:
Constipation	☐	Details:

Anxiety ☐ Details:

Depression ☐ Details:

Psychological / Spiritual ☐ Details:

Social Stressors ☐ Details:

Other (specify) ☐ Details:

SWALLOWING AND INTAKE

Intake: ☐ Normal ☐ Reduced ☐ Sips only ☐ NPO

Difficulty swallowing or chewing: ☐ No ☐ Yes

Current diet order:

EQUIPMENT AND INTERVENTION NEEDS

* *All fields required*

IV in use ☐ No ☐ Yes

IF YES; ☐ Peripheral ☐ Subcutaneous

Central Line ☐ No ☐ Yes

IF YES; date of last flush _____

PICC: ☐ No ☐ Yes

IF YES; Type and number of lumens: _____ Internal/External length: _____

CADD Pump ☐ No ☐ Yes

IF YES; ☐ Epidural

☐ Intrathecal

☐ Other _____

Enteral Feeds ☐ No ☐ Yes

IF YES; Type ☐ PEG ☐ PEJ ☐ NG

Rate ☐ Bolus ☐ Continuous ☐ Frequency _____

Formula/Product _____

Hourly Rate _____ Volume per 24 hours _____

Flush ☐ No ☐ Yes Volume per flush _____

Chest Tube ☐ None ☐ PleurX or tunnelled catheter
☐ Pigtail or small-bore catheter ☐ Large bore catheter
☐ Other _____

Drainage ☐ Gravity Suction [mmH₂0] _____
☐ Continuous suction
☐ Intermittent suction or drainage

Date of last drainage _____

Intermittent drainage details

Abdominal Drain ☐ No ☐ PleurX or tunneled catheter
☐ Pigtail or small-bore catheter ☐ Other _____

Drainage ☐ Gravity Suction [mmH₂0] _____
☐ Continuous suction
☐ Intermittent suction or drainage

Date of last drainage: _____

Intermittent drainage details

Supplemental Oxygen ☐ No ☐ Nasal Prongs ☐ Mask
☐ Other

If YES: lpm _____

CPAP ☐ No ☐ Yes

IF YES: Does patient have own machine? ☐ No ☐ Yes

Frequency of use _____

Settings: _____

BiPAP ☐ No ☐ Yes

IF YES: Does patient have own machine? ☐ No ☐ Yes

Backup Rate ☐ No ☐ Yes

IF YES: Rate: _____

Frequency of use: _____

Settings

Tracheostomy ☐ No ☐ Yes

If YES; ☐ Cuffed Size and brand _____

☐ Uncuffed

Does patient require suctioning? ☐ No ☐ Yes Type and Frequency _____

Other equipment not listed

Type of Mattress in use _____

Wounds ☐ No ☐ Yes

Site/Stage/Dressing

Site/Stage/Dressing

Site/Stage/Dressing

Site/Stage/Dressing

If additional space is needed, use additional information at end of form

Elimination Device ☐ No ☐ Yes

☐ Foley	Supplies Required		Date last changed _____
☐ Colostomy	Supplies required		Date last changed _____
☐ Ileostomy	Supplies required		Date last changed _____
☐ Nephrostomy	Supplies required		Date last changed _____
☐ Ileoconduit	Supplies required		Date last changed _____

ADDITIONAL INFORMATION